RE: Dehydroepiandrosterone supplementation has no added benefit on live birth rate in poor ovarian responders

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TYPE OF ARTICLE: LETTER TO EDITOR

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We read the recently published article in your journal with great interest(1). Due to paucity of literature, the routine use of dehydroepiandrosterone(DHEA) prior to In-vitro fertilisation cycle (IVF) was inconclusive. But this study succeeds in highlighting similar effect of DHEA as compared to a placebo, thus concluding no beneficial effect of DHEA on the live birth rate.

Although the study provides concrete evidence, thus refuting the use of DHEA in IVF cycle, however we as readers would like to enquire the authors about some concerns that can help in better understanding of this randomised trial.

- The study participants were defined according to Bologna criteria, which is now obsolete for defining poor ovarian response. POSEIDON is a more validated criteria for defining poor ovarian response and should be utilised as the inclusion criteria(2). Though the study mentions that a stratified analysis by age (<35 years and [?]35 years) based on the POSEIDON criteria was done, but the detailed result of this analysis is not presented in the study.
- All participants underwent ovarian stimulation using short GnRH agonist protocol but GnRH antagonist is equally good in this group of patients thus requiring less dose of gonadotropins for stimulation(3).
- Though table 2 mentions five different stimulation protocols, but in methodology text only short agonist protocol is mentioned as only the IVF protocol.
- The recommended starting dose of gonadotropins should be 300 rFSH and 150 HMG, but the starting dose was 150-225 IU Menotropins was used, how was the dose titrated and any adjuvants used (2).
- DHEA was administered for a very broad flexible and variable time period i.e. 4-12 weeks in the study. As it is already mentioned that at least three month of DHEA administration is required for maximal effect, therefore only those completing 12 weeks course should have been included in the study.
- It is mentioned that in five participants, three embryos were transferred. But as per ESHRE recommendation, a maximum of two embryos should be transferred in a women of advanced age, thus reducing the risk of multiple gestation (4).
- Standard terminologies for various clinical rate should be used, thus refraining from terminologies like conception and continuing pregnancy as mentioned in table 3.

Disclosure of interests: No conflicts to declare.

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